Medicaid and CHIP Eligibility and Enrollment Performance Indicators

Data Dictionary (November 6, 2013)

1. CALL VOLUME Weekly report—Sunday through Saturday (open enrollment) Monthly report—calendar month (other times)			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
1		Total Call Center Volume	The total number of calls received by each call center during the reporting period. The top-line total should be equal to the sum of the call volume at each individual call center reported.

2. CALL CENTER WAIT TIME Weekly report—Sunday through Saturday (open enrollment) Monthly report—calendar month (other times)			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
2		Average Call Center Wait Time	The average wait time in whole minutes for calls received by each call center during the reporting period. If the state tracks wait time in seconds, round increments of 0 to 29 seconds down to the nearest whole minute, and round increments of 30 to 59 seconds up to the nearest whole minute. If the average wait time is less than 29 seconds, enter 0 and provide an explanation in the data limitations field. If average wait time cannot be provided, leave this field blank (missing) and provide an explanation in the data limitations field. The top-line total should be calculated as the weighted average of each individual call center's wait time during the reporting period. The weighting should be based on the call volumes reported in Indicator 1, "Total Call Center Volume." For example, if a state reported data for 3 call centers in Indicator 1, the weighted average for the call center wait time should be: Call center total average wait time = call center 1 average wait time * (call center 1 volume/call center total volume) + call center 2 average wait time * (call center 2 volume/call center total volume) + call center 3 average wait time * (call center 3 volume/call center total volume)

3. ABANDONMENT RATE Weekly report—Sunday through Saturday (open enrollment) Monthly report—calendar month (other times)			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
3		Average Call Center Abandonment Rate	For each call center or helpline reported in Indicator 1, the abandonment rate equals the number of calls abandoned by caller (numerator) divided by total call volume (denominator). This number should range between 0 and 1, with a zero value representing 0% (no calls abandoned) and a value of one representing 100% (all calls abandoned). The top-line total should be calculated as the weighted average of each individual call center's abandonment rate during the reporting period. The weighting should be based on the call volumes reported in Indicator 1, "Total Call Center Volume." For example, if a state reported data for 3 call centers in Indicator 1, the weighted average for the call center wait time should be: Call center total average abandonment = call center 1 average abandonment rate * (call center 1 volume/call center total volume) + call center 2 average abandonment rate * (call center 2 volume/call center total volume) + call center 3 average. abandonment rate * (call center 3 volume/call center total volume)

4. NUMBER OF APPLICATIONS RECEIVED IN PREVIOUS WEEK Weekly report—Sunday through Saturday (open enrollment)			
Indicator Number	**Data breakout**	**Variable Name**	**Description**
4a		Total Applications Received	Total number of applications received during the reporting period by any state agency with the authority to make Medicaid/CHIP eligibility determinations, including the Medicaid agency, a separate CHIP agency (if one exists in the state), and a state-based marketplace (SBM) (if one exists in the state). Applications for both MAGI and non-MAGI populations should be included. Report applications received through all doorways, including those received by a separate CHIP agency or SBM, and not just applications received directly by the Medicaid agency. Accounts transferred from the federally-facilitated marketplace (FFM) should not be included.
4b	By "Door" Through Which Application Received	Applications Received by Medicaid Agency	Total number of applications received by the Medicaid agency during the reporting period, including applications for both Medicaid and CHIP (if the state does not have a separate CHIP agency). Applications received via an integrated online Marketplace/Medicaid/CHIP portal should not be reported in this indicator; they should be reported in 4d.
4c		Applications Received by CHIP Agency	Total number of applications received by a separate CHIP agency during the reporting period, if there is a separate CHIP agency. If the state does not have a separate CHIP agency, leave the field blank (to indicate this is non-applicable [NA]).
4d		Applications Received by SBM	Total number of applications requesting financial assistance that have been received by the SBM during the reporting period. Applications not requesting for financial assistance should not be included.

5. NUMBER OF APPLICATIONS RECEIVED IN PREVIOUS MONTH Monthly report—calendar month (year round)			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
5a		Total Applications Received	Total number of applications received by any state agency with the authority to make Medicaid/CHIP eligibility determinations, including the Medicaid agency, a separate CHIP agency (if one exists in the state), and a state-based marketplace (if one exists in the state) during the reporting period. Applications for both MAGI and non-MAGI populations should be included. Report applications received through all doorways, including those received by a separate CHIP agency or state-based marketplace (SBM), and not just applications received directly by the Medicaid agency. Accounts transferred from the FFM should not be included. This number should equal the sum of indicators 5b, 5h, and 5n.
5b		Applications Received by Medicaid Agency	Total number of applications received by the Medicaid agency during the reporting period, including applications for both Medicaid and CHIP (if the state does not have a separate CHIP agency). This number should equal the sum of applications received by channel (indicators 5c, 5d, 5e, 5f, and 5g).
5c	Applications Received by Medicaid Agency, by Channel	Online Applications Received by Medicaid Agency	Applications received by Medicaid agency that the applicant filled out and submitted through a web portal or website. Online applications that have been initiated but not yet submitted should not be included in this count.
5d		Mail Applications Received by Medicaid Agency	Paper applications received by the Medicaid agency that the applicant mailed to the Medicaid agency.
5e		In-person Applications Received by Medicaid Agency	Applications that an applicant submitted in-person to a Medicaid agency or caseworker.

5f		Phone Applications Received by Medicaid Agency	Applications that an applicant submitted to the Medicaid agency by answering questions from a call center or hotline agent.
5g		Other Applications Received by Medicaid Agency	All other applications received by the Medicaid agency that cannot be classified as online, mail, in-person, or phone applications. If this is a non-zero value, the data limitations field must include an explanation describing these applications.

5h		Applications Received by CHIP Agency	Total number of applications received by a separate CHIP agency during the reporting period, if there is a separate CHIP agency. If the state does not have a separate CHIP agency, leave the field blank (to indicate this is non-applicable [NA]). This number should equal the sum of applications received by channel (indicators 5i, 5j, 5k, 5l and 5m).
5i	Applications Received by CHIP Agency, by Channel	Online Applications Received by CHIP Agency	Applications received by separate CHIP agency that the applicant filled out and submitted through a web portal or website. Online applications that have been initiated but not yet submitted should not be included in this count.
5j		Mail Applications Received by CHIP Agency	Paper applications received by the separate CHIP agency that the applicant mailed to the separate CHIP agency.
5k		In-person Applications Received by CHIP Agency	Applications that an applicant submitted in-person to a separate CHIP agency or caseworker.
5l		Phone Applications Received by CHIP Agency	Applications that an applicant submitted to the separate CHIP agency by answering questions from a call center or hotline agent.
5m		Other Applications Received by CHIP Agency	All other applications received by the separate CHIP agency that cannot be classified as online, mail, in-person, or phone applications. If this is a non-zero value, the data limitations field must include an explanation describing these applications.
5n		Applications Received by SBM	Total number of applications requesting financial assistance that have been received by the SBM during the reporting period. Applications not requesting financial assistance should not be included.

6. NUMBER OF ELECTRONIC ACCOUNTS TRANSFERRED Weekly report—Sunday through Saturday (open enrollment) Monthly report—calendar month (year round)			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
6a		Total Transfer Accounts Received	Total number of accounts electronically transferred from the FFM to the Medicaid/CHIP agency during the reporting period. SBMs should not report transfers. However, there is one SBM with a non-integrated system and this SBM should report account transfers. Accounts moving between a new integrated system and a legacy system should not be included. An account is defined as the set of application and verification data necessary to make an eligibility determination for an insurance affordability program as required in §435.1200. Only electronic account transfers should be included; case referrals should not be included if an electronic account transfer is not made.
6b	By Source of Incoming Transfer	Transfers Received from FFM	Total number of electronic accounts initially assessed by the FFM before transfer to the Medicaid/CHIP agency for final determination during the reporting period, as well as accounts determined as eligible or ineligible by the FFM before transfer to the Medicaid or CHIP agency. This count should be left as blank (indicating NA) for all reports in until the FFM transfers begin.
6c		Transfers Received from Non-Integrated SBM systems	Total number accounts electronically transferred by an SBM in non-integrated eligibility systems to the Medicaid/CHIP agency during the reporting period. Transfers that occur post-eligibility determination in support of enrollment should not be reported.
6d		Transfers Received from Unknown Source	Total number of electronic account transfers received by the Medicaid/CHIP agency during the reporting period from sources not captured in Indicators 6b and 6c. Explain in the data limitations field any relevant information about the source(s) of these transfers.

6e	By Transfer Type	Determined Account Transfers Received	Total number of electronic accounts during the reporting period in which an individual received a final determination that they were eligible for Medicaid or CHIP from the FFM before account transfer to the state.
6f		Assessed Account Transfers Received	Total number of electronic accounts transferred to the Medicaid/CHIP agency without a final determination of eligibility during the reporting period, including transfer accounts assessed as eligible by the FFM.
6g		Request for Full Determination Transfers Received	Total number of electronic account transfers during the reporting period in which an individual was initially assessed as ineligible for Medicaid or CHIP, but the applicant requested a transfer to the agency for a full determination. Individuals who were assessed as eligible for Medicaid or CHIP before their account was transferred should not be included in this category.
6h		Transfers of Unknown Type Received	Total number of electronic accounts transferred during the reporting period that are not captured in Indicators 6e, 6f, and 6h. Explain in the data limitations field any relevant information about the source(s) of these transfers.
6i		Total Transfer Accounts Sent	Total number of accounts electronically transferred from the Medicaid/CHIP agency to the FFM during the reporting period. Most SBMs (those with integrated eligibility systems for the SBM and Medicaid/CHIP programs) should leave all fields in this section blank (NA).
6j	By Destination	Transfers to FFM	Total number of accounts electronically transferred from the state to the FFM during the reporting period.
6k		Transfers to Non-Integrated SBM Systems	Total number of accounts electronically transferred from the Medicaid/CHIP agency to an SBM with a non-integrated eligibility determination system during the reporting period. Most SBMs (those with integrated eligibility systems for the SBM and Medicaid/CHIP programs) should leave all fields in this section blank (NA).

7. NUMBER OF RENEWALS Monthly report—calendar month (year round)			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
7a		Number of Renewals up for Annual Redetermination	Total number of annual renewals that came up for redetermination by the Medicaid or CHIP agency during the reporting period. These data should include annual renewals only, and exclude beneficiaries redetermined due to a change in circumstances. All annual renewals that came up for redetermination should be included, regardless of the disposition (including pending, determined eligible, determined ineligible, and/or ineligible due to failure to return documentation). This number should equal the sum of Medicaid MAGI, Medicaid non-MAGI, CHIP, and other renewals reported in the four lines below.
7b	By Determination Type	Medicaid MAGI renewals	Total number of Medicaid (Title XIX) renewals that came up for annual redetermination during the reporting period and will be redetermined under MAGI rules.
7c		Medicaid Non-MAGI Renewals	Total number of Medicaid (Title XIX) renewals that came up for annual redetermination during the reporting period and will be redetermined under non-MAGI rules.
7d		CHIP Renewals	Total number of CHIP (Title XXI) renewals that came up for annual redetermination during the reporting period.
7e		Unknown Type	Total number of renewals that came up for annual redetermination during the reporting period but cannot be classified as Medicaid MAGI, Medicaid non-MAGI, or CHIP renewals.

8. TOTAL ENROLLMENT Weekly report—Sunday through Saturday (open enrollment) Monthly report—calendar month (year round)			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
8a		Total Medicaid Enrollees	Total unduplicated number of individuals enrolled in Medicaid as of the last day of the reporting period, including those with retroactive, conditional, and presumptive eligibility. This indicator is a point-in-time count of total program enrollment, and not solely a count of those newly enrolled during the reporting period. Include only those individuals who are eligible for comprehensive benefits (i.e., emergency Medicaid, family planning-only coverage and limited benefit dual eligibles should not be included). Medicaid 1115 Waiver populations should be included as long as the benefits are comprehensive. This number should equal the sum of MAGI and non-MAGI enrollees reported in Indicators 8b and 8e. This number should exclude all enrollees covered under CHIP (Title XXI), who are captured in another Indicator (8h).
8b	Medicaid MAGI enrollment	Total MAGI Enrollees	Total unduplicated number of individuals enrolled in Medicaid as of the last day of the reporting period who were determined into the program using MAGI determination rules.
8c		MAGI Child Enrollees	Total unduplicated number of individuals enrolled in Medicaid (Title XIX) as of the last day of the reporting period who are children and who were determined into the program using MAGI determination rules. A state should use its definition of "child" as included in its Medicaid or CHIP state plan.
8d		MAGI Adult Enrollees	Total unduplicated number of individuals enrolled in Medicaid as of the last day of the reporting period, other than children, who were determined into the program using MAGI determination rules. This number should include all MAGI enrollees who were not children.
8e	Medicaid non-MAGI enrollment	Total Non-MAGI Enrollees	Total unduplicated number of individuals enrolled in Medicaid as of the last day of the reporting period who were determined into the program using non-MAGI determination rules.
8f		Non-MAGI Child Enrollees	Total unduplicated number of children enrolled in Medicaid (Title XIX) as of the last day of the reporting period, who were determined into the program using non-MAGI determination rules. A state should use its definition of "child" as included in its Medicaid or CHIP state plan.
8g		Non-MAGI Adult Enrollees	Total unduplicated number of individuals, other than children, enrolled in Medicaid as of the last day of the reporting period, who were determined into the program using non-MAGI determination rules. This number should include all non-MAGI enrollees who were not children.

8h		Total CHIP Enrollees	Total unduplicated number of individuals, other than children, enrolled in CHIP (Title XXI) as of the last day of the reporting period, including those with retroactive, conditional, and presumptive eligibility. CHIP children in a premium grace period should be included, while CHIP children subject to a waiting period or premium lock-out period are considered eligible but not enrolled and should be excluded. This indicator is a point-in-time count of total program enrollment, and not solely a count of those newly enrolled during the reporting period.

9. TOTAL NUMBER OF INDIVIDUALS DETERMINED ELIGIBLE Weekly report—Sunday through Saturday (open enrollment) Monthly report—calendar month (year round)			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
9a		Total Medicaid Eligible	Total number of individuals determined eligible for Medicaid (Title XIX) under either MAGI or non-MAGI rules during the reporting period. This count should include determinations following an initial application as well as all redeterminations (triggered by either the annual renewal process or other change in circumstances). Individuals determined eligible for CHIP (Title XXI) should not be included, as they are captured in another Indicator (9h). All determinations made in the reporting period should be included, even if the individual will not be enrolled into the program during the reporting period or is found retroactively eligible. Include final determinations made by any state agency, including the Medicaid agency, a separate CHIP agency, and an SBM. Include determinations made on accounts assessed by the FFM and transferred to Medicaid for final determination. Do not include final eligibility determinations made by the FFM and transferred to Medicaid for enrollment. If an individual receives a MAGI and then a non-MAGI determination, both of these separate determinations should be counted.
9b	By Determination Type	Medicaid MAGI Eligibility Determinations	Total number of individuals determined eligible for Medicaid (Title XIX) under MAGI rules during the reporting period.
9c		Medicaid non-MAGI Eligibility Determinations	Total number of individuals determined eligible for Medicaid (Title XIX) under non-MAGI rules during the reporting period.

9d	By Reason for Determination	Medicaid Eligibility Determined at Application	Total number of individuals determined eligible for Medicaid (Title XIX) under either MAGI or non-MAGI rules during the reporting period based on applications for coverage submitted to any state agency (Medicaid, CHIP, or the SBM). Include accounts assessed as eligible and transferred from the FFM. Do not include accounts determined eligible by the FFM.
9e		Medicaid Eligibility Determined at Annual Renewal	Total number of individuals determined eligible for Medicaid (Title XIX) at annual renewal under either MAGI or non-MAGI rules during the reporting period. Individuals redetermined outside of the annual renewal process (for example, due to a change in circumstance) should not be reported here, as they are captured in another Indicator (9g).
9f		Medicaid Eligible via Administrative Determination	Total number of individuals determined eligible for Medicaid (Title XIX) during the reporting period without submitting an application, under the process by which a state determines a cohort of individuals eligible through targeted enrollment strategies outlined in CMS guidance issued on May 17, 2013. This includes enrolling certain SNAP participants and parents of CHIP beneficiaries without requiring an application. Unless your state has been approved by CMS to make this type of determination, leave this field blank (NA).
9g		Medicaid Eligible via Other Method	Total number of individuals determined eligible for Medicaid (Title XIX) under both MAGI and non-MAGI rules during the reporting period that are not captured in Indicators 9d, 9e, and 9f. This number should include redeterminations made outside of the annual renewal process (for instance, due to a self-reported change in circumstance).
9h		Total CHIP Eligible	Total number of individuals determined eligible for CHIP (Title XXI) during the reporting period. This number should include determinations following an initial application as well as all redeterminations (triggered by either the annual renewal process or other change in circumstances). All determinations made in the reporting period should be included, even if the individual will not be enrolled into the program during the reporting period or is found retroactively eligible. Include determinations made by any state agency, including the Medicaid agency, a separate CHIP agency, and an SBM. Include determinations made on accounts assessed by the FFM and transferred to Medicaid for final determination. Do not include final eligibility determinations made by the FFM and transferred to Medicaid for enrollment.

9i	By Reason for Determination	Determined CHIP Eligible at Application	Total number of individuals determined eligible for CHIP (Title XXI) during the reporting period that follows the applicant submitting an application for coverage to any state agency (Medicaid, CHIP, or the SBM). Do not include accounts determined eligible by the FFM.
9j		Determined CHIP Eligible at Annual Renewal	Total number of individuals determined eligible for CHIP (Title XXI) at annual renewal during the reporting period. Individuals redetermined outside of the annual renewal process (for example, due to a change in circumstance) should not be reported here, as they are captured in another Indicator (9k).
9k		All Others Determined CHIP Eligible	Total number of individuals determined eligible for CHIP (Title XXI) during the reporting period who are not captured in Indicators 9i and 9j. This includes redeterminations made outside of the annual renewal process (for instance, due to a change in circumstance).

10. TOTAL NUMBER OF INDIVIDUALS DETERMINED INELIGIBLE Weekly report—Sunday through Saturday (open enrollment) Monthly report—calendar month (year round)			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
10a		Total Medicaid Ineligible	Total number of individuals determined ineligible for Medicaid (Title XIX) under either MAGI or non-MAGI rules during the reporting period. This number should include determinations following an initial application as well as all redeterminations (triggered by either the annual renewal process or other change in circumstances). Include final determinations made by any state agency, including the Medicaid agency, a separate CHIP agency, and an SBM. Include individuals determined ineligible by a state agency after their account was assessed and transferred from the FFM. Do not include final eligibility determinations made by the FFM. Individuals determined ineligible for CHIP (Title XXI) without being determined ineligible for Medicaid (Title XIX) should not be included in this Indicator, as they are captured in Indicator 9h. Individuals who request disenrollment during the reporting period should also be excluded from this Indicator.
10b	By Determination Reason	Medicaid Determination – Ineligibility Established	Total number of individuals determined ineligible for Medicaid (Title XIX) under either MAGI or non-MAGI rules during the reporting period based on information known to the state agency making the determination (for instance, individuals determined ineligible due to death, aging out, citizenship status, changes in household composition, or higher income).
10c		Medicaid Determination – Eligibility Cannot be Established	Total number of individuals determined ineligible for Medicaid (Title XIX) under either MAGI or non-MAGI rules during the reporting period because they failed to complete or return renewal forms or other required documentation, or who were lost to follow up.

10d	By Type of Determination	Medicaid Determination – Ineligible at Application	Total number of individuals determined ineligible for Medicaid (Title XIX) under either MAGI or non-MAGI rules during the reporting period as a result of the applicant submitting an application for coverage to any state agency (Medicaid, CHIP, or the SBM). Include individuals determined ineligible by a state agency after their account was assessed and transferred from the FFM. Do not include final eligibility determinations made by the FFM.
10e		Medicaid Determination – Ineligible at Annual Renewal	Total number of individuals who, during the reporting period, were determined ineligible for Medicaid (Title XIX) at annual renewal under either MAGI or non-MAGI rules. Individuals redetermined outside of the annual renewal process (for example, due to a change in circumstance) should not be reported here, as they are captured in another Indicator (10f).
10f		Medicaid Determination – Ineligible via Other Application Type	Total number of individuals determined ineligible for Medicaid (Title XIX) under both MAGI and non-MAGI rules during the reporting period who are not captured in Indicators 10d and 10e. This could include redeterminations made outside of the annual renewal process (for instance, due to a change in circumstance).
10g		Total CHIP Ineligible	Total number of individuals determined ineligible for CHIP (Title XXI) during the reporting period. This number should include determinations following an initial application as well as all redeterminations (triggered by either the annual renewal process or other change in circumstances). Include final determinations made by any state agency, including the Medicaid agency, a separate CHIP agency, and an SBM. Include individuals determined ineligible by a state agency after their account was assessed and transferred from the FFM. Do not include final eligibility determinations made by the FFM. Individuals who request disenrollment or are disenrolled for failure to make premium payments during the reporting period should not be included in this Indicator. Similarly, children subject to a waiting period or premium lock-out period are considered eligible but not enrolled and should also be excluded from this Indicator.

10h	By Determination Reason	CHIP Determination – Ineligibility Established	Total number of individuals determined ineligible for CHIP (Title XXI) during the reporting period based on information known to the state agency making the determination (for instance, individuals determined ineligible due to death, aging out, citizenship status, changes in household composition, or higher income).
10i		CHIP Determination – Eligibility Cannot be Established	Total number of individuals determined ineligible for CHIP (Title XXI) during the reporting period because they failed to complete or return renewal forms or other required documentation, or who were lost to follow up.
10j	By Determination Type	CHIP Determination – Ineligible at Application	Total number of individuals determined ineligible for CHIP (Title XXI) during the reporting period as a result of the applicant submitting an application for coverage to any state agency (Medicaid, CHIP, or the SBM). Include individuals determined ineligible by a state agency after their account was assessed and transferred from the FFM Include individuals determined ineligible by a state agency after their account was assessed and transferred from the FFM. Do not include final eligibility determinations made by the FFM.
10k		CHIP Determination – Ineligible at Annual Renewal	Total number of individuals determined ineligible for CHIP (Title XXI) at annual renewal during the reporting period. Individuals redetermined outside of the annual renewal process (for example, due to a change in circumstance) should not be reported here, as they are captured in another Indicator (10l).
10l		CHIP Determination – Ineligible via Other Application Type	Total number of individuals determined ineligible for CHIP (Title XXI) during the reporting period who are not captured in Indicators 10j and 10k. This could include redeterminations made outside of the annual renewal process (for instance, due to a change in circumstance).

11. NUMBER OF PENDING APPLICATIONS OR REDETERMINATIONS Monthly report—calendar month (year round)			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
11a	Pending at Medicaid Agency	Number Pending at Medicaid Agency	Total number of applications and redeterminations pending at Medicaid agency as of the last day of the month. This includes all applications that have been received by the agency (regardless of the date of application) and outstanding redetermination (regardless of when the individual came up for renewal), but which have not yet been determined as of the last day of the month. Online applications that have been initiated but not yet submitted to the Medicaid agency should be excluded. If the Medicaid agency administers eligibility for the CHIP program, then pending CHIP applications and redeterminations should be included in this count.
11b		Pending at Medicaid Agency Type	States where the number of pending applications and redeterminations reported in Indicator 11a are of individuals should report "I" in this field. States where the reported number are of cases that may include a mix of individuals and households should report "A" in this field.
11c	Pending at Separate CHIP Agency	Number Pending at CHIP Agency	Total number of applications and redeterminations pending at the separate CHIP agency as of the last day of the month. This includes all applications that have been received by the agency (regardless of the date of application) and outstanding redetermination (regardless of when the individual came up for renewal), but which have not yet been determined as of the last day of the month. Online applications that have been initiated but not yet submitted to the separate CHIP agency should be excluded. If the state does not have a separate CHIP agency, this Indicator and Indicator 11d should be left blank (NA).
11d		Pending at Separate CHIP Agency Type	States where the number of pending applications and redeterminations reported in Indicator 11c are of individuals should report "I" in this field. States where the reported numbers are of cases that may include a mix of individuals and households should report "A" in this field.

12. PROCESSING TIME FOR DETERMINATIONS Monthly report—calendar month (year round)			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
12a		Median Processing Time – All Medicaid Determinations	For all applicants (regardless of date of application) who received a determination from the Medicaid agency in the reporting period, report the median number of calendar days elapsed between the date the Medicaid agency received the initial application (start date) and the day the determination at initial application was made (end date). The set of determinations included in the calculation of median processing time for this measure includes Medicaid and CHIP determinations made by the Medicaid agency; MAGI and non-MAGI determinations; and determinations where the applicants was determined eligible as well as those where the applicant was determined ineligible. All determinations within the reporting period should be included, regardless of when the application was submitted. If multiple household members applied on a single application, the processing time should be calculated and reported separately for each individual who received a determination. Individuals with presumptive eligibility should not be included in this Indicator, as they have not yet received a final determination.
12b	Type of Medicaid Determination	Median Processing Time – MAGI Determinations	The median processing time, in days, as defined in Indicator 12a, but only for the set of final determinations that the Medicaid agency made using MAGI rules. All CHIP determinations made by the Medicaid agency should be included in this calculation.
12c		Median Processing Time – non-MAGI Determinations	The median processing time, in days, as defined in Indicator 12a, but only for the set of final determinations that the Medicaid agency made using non-MAGI rules. No CHIP (Title XXI) determinations should be included in this calculation.

12d	Source of Medicaid Application	Median Processing Time – Direct Application	The median processing time, in days, as defined in Indicator 12a, but only for the set of final determinations that the Medicaid agency made on Medicaid or CHIP applications that the applicant submitted directly to the state, including if the application was submitted directly to an SBM..
12e		Median Processing Time – Transfer Application from FFM	The median processing time, in days, as defined in Indicator 12a, but only for the set of final determinations that the Medicaid agency made on Medicaid or CHIP applications that were transferred to it by the FFM. States with an SBM should leave this field blank (NA).
12f	Number of Medicaid MAGI Determinations, by Processing Time	Less than 24 Hours	The number of final determinations made by the Medicaid agency using MAGI rules that occurred within 24 hours of the time that the application was received by the agency. The sum of this Indicator, and Indicators 12h, 12i, 12j, and 12k should equal the total number of determinations at initial application that the Medicaid agency made under MAGI rules in the previous month. This includes determinations made on transfer applications received by the Medicaid agency.
12g		24 Hours – 7 Days	The number of final determinations made by the Medicaid agency using MAGI rules that occurred between 24 hours and 7 days of when the application was received by the agency.
12h		8 Days – 30 Days	The number of final determinations made by the Medicaid agency using MAGI rules that occurred between 8 and 30 days of when the application was received by the agency.
12i		31 Days – 45 Days	The number of final determinations made by the Medicaid agency using MAGI rules that occurred between 31 and 45 days of when the application was received by the agency.
12j		More than 45 Days	The number of final determinations made by the Medicaid agency using MAGI rules that occurred more than 45 days after the date that the application was received by the agency.
12k	Number of Medicaid non-MAGI Applications, by Processing Time	Less than 30 Days	The number of final determinations made by the Medicaid agency using non-MAGI rules that occurred within 30 days of the date that the application was received by the agency. The sum of this Indicator and Indicators 12l, 12m, 12n, and 12o should equal the total number of determinations at initial application that the Medicaid agency made under non-MAGI rules in the previous month. This includes determinations made on transfer applications received by the Medicaid agency.
12l		31 – 60 Days	The number of final determinations made by the Medicaid agency using non-MAGI rules that occurred between 31 and 60 days of when the application was received by the agency.
12m		61 – 90 Days	The number of final determinations made by the Medicaid agency using non-MAGI rules that occurred between 60 and 90 days of when the application was received by the agency.

12n		More than 90 days	The number of final determinations made by the Medicaid agency using non-MAGI rules that occurred more than 90 days after the date that the application was received by the agency.
12o		Median Processing Time – separate CHIP Agency	For all applicants (regardless of date of application) who received a final determination from the separate CHIP agency in the reporting period, report the median number of calendar days elapsed between the date the agency received the application (start date) and the day the final determination was made (end date). The set of determinations included in the calculation of median processing time for this measure includes both determinations where the applicants was determined eligible as well as those where the applicant was determined ineligible. All determinations within the reporting period should be included, regardless of when the application was submitted. If multiple household members applied on a single application, the processing time should be calculated and reported separately for each individual who received a determination. Individuals with presumptive eligibility should not be included in this Indicator, as they have not yet received a final determination. In states without a separate CHIP agency, this Indicator as well as Indicators 12p and 12q should be left blank (NA).
12p	Source of CHIP Application	Median Processing Time – Direct Application	The median processing time in days as defined in Indicator 12o, but only for the set of final determinations that the separate CHIP agency made on applications that the applicant submitted directly to the state.
12q		Median Processing Time – Transfer Application from FFM	The median processing time in days as defined in Indicator 12o, but only for the set of final determinations that the separate CHIP agency made on applications that were transferred to it by the FFM. States that share an integrated eligibility system with the SBM should leave this field blank (NA).

12r	Number of CHIP Applications, by Processing Time	Less than 24 Hours	The number of final determinations made by the separate CHIP agency using MAGI rules that occurred within 24 hours of the time that the application was received by the agency. The sum of this Indicator and Indicators 12s, 12t, 12u, and 12v, should equal the total number of determinations at initial application that the separate CHIP agency made under MAGI rules in the previous month. This includes determinations on transfer applications that the separate CHIP agency received from the FFM, SBM, or Medicaid agency. In states without a separate CHIP agency, this Indicator and Indicators 12s, 12t, 12u, and 12v should be left blank (NA).
12s		24 Hours – 7 Days	The number of final determinations made by the separate CHIP agency using MAGI rules that occurred between 24 hours and 7 days of when the application was received by the agency.
12t		8 Days – 30 Days	The number of final determinations made by the separate CHIP agency using MAGI rules that occurred between 8 and 30 days of when the application was received by the agency.
12u		31 Days – 45 Days	The number of final determinations made by the separate CHIP agency using MAGI rules that occurred between 31 and 45 days of when the application was received by the agency.
12v		More than 45 Days	The number of final determinations made by the separate CHIP agency using MAGI rules that occurred more than 45 days after the date that the application was received by the agency.